

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06899

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Woodbine		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Woodbine	
3. NAME OF DECEASED (Type or print) First JESSE Middle T. Last BRIGHTWELL		d. STREET ADDRESS Daisy	
4. DATE OF DEATH Month JUNE Day 25, Year 19 58		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-1876
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles S. Brightwell		14. MOTHER'S MAIDEN NAME Alice A. Bloom	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Cora L. Brightwell, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1wk 5yrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George E. Burgtorf		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George E. Burgtorf		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6-25-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-27-1958	
22c. NAME OF CEMETERY OR CREMATORY Poplar Springs		22d. LOCATION (City, town, or county) (State) Howard Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Md.		24a. REC'D BY REGISTRAR JUN 27 '58	
24b. REGISTRAR'S SIGNATURE		DATE	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Blank]		SEX [Blank]	
AGE [Blank]		RACE [Blank]	
DATE OF DEATH [Blank]		PLACE OF DEATH [Blank]	
TIME OF DEATH [Blank]		PLACE OF BIRTH [Blank]	
OCCUPATION [Blank]		MARITAL STATUS [Blank]	
CAUSE OF DEATH [Blank]		MANNER OF DEATH [Blank]	
SIGNATURE OF EXAMINER [Blank]		SIGNATURE OF WITNESS [Blank]	
DATE OF EXAMINATION [Blank]		TIME OF EXAMINATION [Blank]	
PLACE OF EXAMINATION [Blank]		NAME OF HOSPITAL [Blank]	
NAME OF PHYSICIAN [Blank]		NAME OF NURSE [Blank]	
NAME OF CHAPLAIN [Blank]		NAME OF MINISTER [Blank]	
NAME OF CLERGYMAN [Blank]		NAME OF OTHER [Blank]	
NAME OF FUNERAL HOME [Blank]		NAME OF CEMETERY [Blank]	
NAME OF BURIAL PLACE [Blank]		NAME OF INTERMENT [Blank]	
NAME OF CREMATOR [Blank]		NAME OF CREMATION [Blank]	
NAME OF INCINERATOR [Blank]		NAME OF INCINERATION [Blank]	
NAME OF BURIAL PLACE [Blank]		NAME OF INTERMENT [Blank]	
NAME OF CREMATOR [Blank]		NAME OF CREMATION [Blank]	
NAME OF INCINERATOR [Blank]		NAME OF INCINERATION [Blank]	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6906

## CERTIFICATE OF DEATH

06900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6330 Old Washington Rd</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b> d. STREET ADDRESS <b>6330 Old Washington Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas Leroy Bush</b>		4. DATE OF DEATH <b>June 20, 1958</b> Month <b>June</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 8, 1891</b> 9. AGE (In years last birthday) <b>67</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Dept., Packer Brandt Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Elkridge Md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Elizah Bush</b>		14. MOTHER'S MAIDEN NAME <b>Anna Bowers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Madeline E. Bush</b>		Address <b>6330 Old Washington Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> <b>421.1</b> DUE TO <b>arterial &amp; mitral disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocardial infarction</b> DUE TO (c) <b>arterial hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>2 yrs</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic arthritis &amp; deformed spine</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 1957</b> , to <b>June 20, 1958</b> , that I last saw the deceased alive on <b>June 19, 1958</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5509 Main St Elkridge Md</b> DATE SIGNED <b>6/20/58</b>			
ACTUAL SIGNATURE <b>B B Brumbaugh</b> M.D.		PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/23/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Augustine</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave.</b>	
24a. REC'D BY REGISTRAR <b>JUN 23 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. medich</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 1

Howard

Howard

Howard

Life

Howard

2350 Old Washington Rd.

2350 Old Washington Rd.

June 20, 1968

Thomas J. Howard

51

Jan. 1, 1911

Male

Howard

Howard, Baker Bros. Co.

Anna Howard

Miss E. Howard

Residence: 2350 Old Washington Rd.

None

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6907

## CERTIFICATE OF DEATH

06901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b>				c. LENGTH OF STAY IN 1b <b>88 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				d. STREET ADDRESS <b>None</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>AGNES</b> Last <b>GOONEY</b>				4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 10, 1870</b>	
9. AGE (In years last birthday) <b>88</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>8</b> Hours <b>15</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Howard County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas French</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Max Smith Clarksville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic heart failure</b> DUE TO <b>Arteriosclerotic heart disease with</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary insufficiency</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>  <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-4-</b> <b>1956</b> to <b>6-8-</b> <b>1958</b> , that I last saw the deceased alive on <b>6-8-</b> <b>1958</b> , and that death occurred at <b>6:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Clarksville, Maryland</b> DATE SIGNED <b>6-8-58</b>							
ACTUAL SIGNATURE <b>Charles S. Whitaker, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 11, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons, Catonsville 28, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6908

## CERTIFICATE OF DEATH

Reg. Dist. No.

06902

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's Co			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				d. STREET ADDRESS 18 X-2			
3. NAME OF DECEASED (Type or print) First J Middle Raley Last Cullins				4. DATE OF DEATH Month June 3 Day 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/18/90	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Store keeper				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Mary's Co, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William Edward Cullins				14. MOTHER'S MAIDEN NAME Mary Elizabeth Russell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Now				16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mrs Eloise S. Cullins Palmers, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 X Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis due to cerebral arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/23/58, 19 to June 3, 19 58, that I last saw the deceased alive on June 3, 19 58, and that death occurred at 9:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Taylor Manor Hospital June 3, 1958							
ACTUAL SIGNATURE Irving J. Taylor				PHYSICIAN'S NAME (Type) Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/6/58		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Bushwood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Maryland		24a. REC'D BY REGISTRAR DATE JUN 6 '58	
				24b. REGISTRAR'S SIGNATURE W. Clarke			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. PLACE OF DEATH Baltimore, Maryland		12. DATE OF DEATH April 4, 1968		13. TIME OF DEATH 2:01 PM		14. CAUSE OF DEATH Gunshot wound of the chest		15. MANNER OF DEATH Suicide	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover		19. SIGNATURE OF WITNESS J. Edgar Hoover		20. SIGNATURE OF WITNESS J. Edgar Hoover	
21. SIGNATURE OF WITNESS J. Edgar Hoover		22. SIGNATURE OF WITNESS J. Edgar Hoover		23. SIGNATURE OF WITNESS J. Edgar Hoover		24. SIGNATURE OF WITNESS J. Edgar Hoover		25. SIGNATURE OF WITNESS J. Edgar Hoover	
26. SIGNATURE OF WITNESS J. Edgar Hoover		27. SIGNATURE OF WITNESS J. Edgar Hoover		28. SIGNATURE OF WITNESS J. Edgar Hoover		29. SIGNATURE OF WITNESS J. Edgar Hoover		30. SIGNATURE OF WITNESS J. Edgar Hoover	
31. SIGNATURE OF WITNESS J. Edgar Hoover		32. SIGNATURE OF WITNESS J. Edgar Hoover		33. SIGNATURE OF WITNESS J. Edgar Hoover		34. SIGNATURE OF WITNESS J. Edgar Hoover		35. SIGNATURE OF WITNESS J. Edgar Hoover	
36. SIGNATURE OF WITNESS J. Edgar Hoover		37. SIGNATURE OF WITNESS J. Edgar Hoover		38. SIGNATURE OF WITNESS J. Edgar Hoover		39. SIGNATURE OF WITNESS J. Edgar Hoover		40. SIGNATURE OF WITNESS J. Edgar Hoover	
41. SIGNATURE OF WITNESS J. Edgar Hoover		42. SIGNATURE OF WITNESS J. Edgar Hoover		43. SIGNATURE OF WITNESS J. Edgar Hoover		44. SIGNATURE OF WITNESS J. Edgar Hoover		45. SIGNATURE OF WITNESS J. Edgar Hoover	
46. SIGNATURE OF WITNESS J. Edgar Hoover		47. SIGNATURE OF WITNESS J. Edgar Hoover		48. SIGNATURE OF WITNESS J. Edgar Hoover		49. SIGNATURE OF WITNESS J. Edgar Hoover		50. SIGNATURE OF WITNESS J. Edgar Hoover	
51. SIGNATURE OF WITNESS J. Edgar Hoover		52. SIGNATURE OF WITNESS J. Edgar Hoover		53. SIGNATURE OF WITNESS J. Edgar Hoover		54. SIGNATURE OF WITNESS J. Edgar Hoover		55. SIGNATURE OF WITNESS J. Edgar Hoover	
56. SIGNATURE OF WITNESS J. Edgar Hoover		57. SIGNATURE OF WITNESS J. Edgar Hoover		58. SIGNATURE OF WITNESS J. Edgar Hoover		59. SIGNATURE OF WITNESS J. Edgar Hoover		60. SIGNATURE OF WITNESS J. Edgar Hoover	
61. SIGNATURE OF WITNESS J. Edgar Hoover		62. SIGNATURE OF WITNESS J. Edgar Hoover		63. SIGNATURE OF WITNESS J. Edgar Hoover		64. SIGNATURE OF WITNESS J. Edgar Hoover		65. SIGNATURE OF WITNESS J. Edgar Hoover	
66. SIGNATURE OF WITNESS J. Edgar Hoover		67. SIGNATURE OF WITNESS J. Edgar Hoover		68. SIGNATURE OF WITNESS J. Edgar Hoover		69. SIGNATURE OF WITNESS J. Edgar Hoover		70. SIGNATURE OF WITNESS J. Edgar Hoover	
71. SIGNATURE OF WITNESS J. Edgar Hoover		72. SIGNATURE OF WITNESS J. Edgar Hoover		73. SIGNATURE OF WITNESS J. Edgar Hoover		74. SIGNATURE OF WITNESS J. Edgar Hoover		75. SIGNATURE OF WITNESS J. Edgar Hoover	
76. SIGNATURE OF WITNESS J. Edgar Hoover		77. SIGNATURE OF WITNESS J. Edgar Hoover		78. SIGNATURE OF WITNESS J. Edgar Hoover		79. SIGNATURE OF WITNESS J. Edgar Hoover		80. SIGNATURE OF WITNESS J. Edgar Hoover	
81. SIGNATURE OF WITNESS J. Edgar Hoover		82. SIGNATURE OF WITNESS J. Edgar Hoover		83. SIGNATURE OF WITNESS J. Edgar Hoover		84. SIGNATURE OF WITNESS J. Edgar Hoover		85. SIGNATURE OF WITNESS J. Edgar Hoover	
86. SIGNATURE OF WITNESS J. Edgar Hoover		87. SIGNATURE OF WITNESS J. Edgar Hoover		88. SIGNATURE OF WITNESS J. Edgar Hoover		89. SIGNATURE OF WITNESS J. Edgar Hoover		90. SIGNATURE OF WITNESS J. Edgar Hoover	
91. SIGNATURE OF WITNESS J. Edgar Hoover		92. SIGNATURE OF WITNESS J. Edgar Hoover		93. SIGNATURE OF WITNESS J. Edgar Hoover		94. SIGNATURE OF WITNESS J. Edgar Hoover		95. SIGNATURE OF WITNESS J. Edgar Hoover	
96. SIGNATURE OF WITNESS J. Edgar Hoover		97. SIGNATURE OF WITNESS J. Edgar Hoover		98. SIGNATURE OF WITNESS J. Edgar Hoover		99. SIGNATURE OF WITNESS J. Edgar Hoover		100. SIGNATURE OF WITNESS J. Edgar Hoover	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT TO BE USED FOR ANY OTHER PURPOSE.



6909

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06903

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City (rural)</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City (rural)</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Owen Brown Road</b>			d. STREET ADDRESS <b>Owen Brown Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>Catherine</b> Last <b>Ketterman</b>			4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>19 58</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1898</b>		9. AGE (In years last birthday) <b>60</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>Sarah May (last name)</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Bessie Ketterman, Ellicott City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary artery occlusion</b> (c) <b>instant</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>instant</b>					INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Whitaker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>June 24, 1958</b>	
EXAMINER'S NAME (Type) <b>Charles S. Whitaker, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6/26/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>	
22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. HIGINBOTHOM</b>		ADDRESS <b>Ellicott City, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 27 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. B. Search</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE  
DEPARTMENT

Howland

Howland

Howland

Ellicott City (Maryland)

Ellicott City (Maryland) 1 Year

Web Brown Road

Owen Brown Road

58

June 24

Robertson

Robertson

Robertson

May 14, 1906

White

Female

West Virginia

Home

Housewife

May (last name)

Robert

Unknown

Mr. Basil Robertson, Ellicott City, Md.

Home

No

Acute cardiac failure

Coronary artery occlusion

Instant

Instant

June 24, 1906

Charles G. Whittaker, M.D.

Home

Home

Ellicott City, Md.

Ellicott City, Md.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06904

Reg. Dist. No.

6910

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b> <b>3y 1-4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>River Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Raymond L. Klingenberg</b>		4. DATE OF DEATH <b>June 23 19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/28/02</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter &amp; Paperhanger</b>		12. CITIZEN OF WHAT COUNTRY <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>John Henry Klingenberg</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Kuestner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Mrs. Raymond Klingenberg, Jr. Balto, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none (b) none (c) none INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>George E. Burgtorf</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>George E. Burgtorf</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6/23/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/27/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>	22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, Inc.</b>		ADDRESS <b>715 Light St.</b>	
24a. REC'D BY REGISTRAR <b>DATE JUN 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alb. Leach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH USE

DATE OF BIRTH

Boards

Examination

History Book

Examination

White

Belts

John Henry Jones

to. H. H. Jones

Examination

to

Examination

Boards

Examination

Boards

Examination

Boards

Examination

Boards

Boards

6911

## CERTIFICATE OF DEATH

06905

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Elbridge</u>		c. LENGTH OF STAY IN IT <u>17 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Blvd W. Elbridge</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Tallulah B. Kohlhoff</u>		DATE OF DEATH <u>6/15/58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1909</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward W. Montour</u>		14. MOTHER'S MAIDEN NAME <u>Anna L. Simpson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Edward B. Kohlhoff</u>		Address <u>Washington Blvd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Rectum</u> <u>154X</u> DUE TO <u>2nd General Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Second stage anemia</u> (c) <u>2 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1957</u> , to <u>June 5, 1958</u> , that I last saw the deceased alive on <u>June 5, 1958</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B B Brumbaugh</u> M.D.		ADDRESS (Street, city or town, state) <u>1609 Main St</u> DATE SIGNED <u>6/15/58</u>	
PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>		<u>Elbridge 27 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowdale</u>	22d. LOCATION (City, town, or county) (State) <u>W. Elbridge Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Brown</u>		ADDRESS <u>901 2nd St</u>	
24a. REC'D BY REGISTRAR <u>JUN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Elbridge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6912

## CERTIFICATE OF DEATH

Reg. Dist. No. 06906

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City (Glenelg)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Glenelg</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIA</b> Middle <b>MEDIA</b> Last <b>LINTHICUM</b>				4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-15-1869</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>John Melia</b>				14. MOTHER'S MAIDEN NAME <b>Martha M<sup>c</sup> LINTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Louise Phelps, Glenelg, Md</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery occlusion</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>5 minutes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-12-</b> 19 <b>46</b> , to <b>6-11-</b> 19 <b>58</b> , that I last saw the deceased alive on <b>6-9-</b> 19 <b>58</b> , and that death occurred at <b>10:00P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Clarksville, Maryland</b> DATE SIGNED <b>6-12-58</b> ACTUAL SIGNATURE <b>Charles S. Whitaker</b> M.D. PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-14-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Louis</b>		22d. LOCATION (City, town, or county) (State) <b>Clarksville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b> ADDRESS				24a. REC'D BY REGISTRAR <b>JUN 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Dee Leach</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6913

Item 8 F. 1100230 1-2-50 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 06907

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Savage</b> c. LENGTH OF STAY IN b <b>18 yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>XXXXXX</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Savage</b> d. STREET ADDRESS <b>Savage-Guilford Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elaine Auonette Mayhugh</b> First Middle Last 4. DATE OF DEATH <b>6 19 1958</b> Month Day Year				5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Oct 31, 1914</b> 9. AGE (In years last birthday) <b>44</b> 10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>X X X X</b> 11. BIRTHPLACE (State or foreign country) <b>Savage, Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>				13. FATHER'S NAME <b>Albert Mayhugh</b> 14. MOTHER'S MAIDEN NAME <b>Iola Slater</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Mrs. Iola Mayhugh, Savage, Md.</b> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Overwhelming Toxemia</b> <b>045.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bacillary Dysentery</b> DUE TO (c) <b>Mentally Retarded</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>12/2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/18/58</b> , 19 <b>58</b> , and that death occurred at <b>4A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Laurel, Md</b> DATE SIGNED <b>June 21, 1958</b> ACTUAL SIGNATURE <b>J. M. Warren M.D.</b> PHYSICIAN'S NAME (Type) <b>J. M. Warren</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>June 22, 1958</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Ivy Hill</b> 22d. LOCATION (City, town, or county) (State) <b>Laurel, Pence Geo. - Md.</b>				23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Henderson</b> ADDRESS <b>Laurel, Md.</b> 24a. REC'D BY REGISTRAR DATE <b>JUN 24 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. Couch</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>William J. Smith</i></p>	
<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>	
<p>4. Date of death: <i>10/15/1917</i></p>	
<p>5. Place of death: <i>Home</i></p>	
<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>Dr. J. H. Smith</i></p>	
<p>8. Signature of registrar: <i>John Doe</i></p>	
<p>9. Date of registration: <i>10/16/1917</i></p>	
<p>10. Place of registration: <i>New York City</i></p>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6914

## CERTIFICATE OF DEATH

Reg. Dist. No.

06908

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Columbia Road</b>		d. STREET ADDRESS <b>Columbia Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>Lee</b> Last <b>McDonald</b>		4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 19, 1892</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Bell</b>		14. MOTHER'S MAIDEN NAME <b>Mary Louise Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>M/Sgt. Sabille E. McDonald, Ellicott City, Md</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis (Generalized)</b> <b>170x</b> DUE TO <b>Carcinoma of Breast (Left)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>8 months 6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 1949</b> , to <b>June 3, 1958</b> , that I last saw the deceased alive on <b>May 29, 1958</b> , and that death occurred at <b>10:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Grafton Hersperger</b> M.D.		ADDRESS (Street, city or town, state) <b>214 Medical Arts Bldg.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>W. Grafton Hersperger, M.D.</b>		<b>214 Medical Arts Bldg., Balti. 1, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 6/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenhill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Berryville, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b>		ADDRESS <b>4101 Edmondson Ave.</b>	
24a. REC'D BY REGISTRAR <b>JUN 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

<p>NAME OF DECEASED Howard</p>		<p>DATE OF DEATH June 2, 1958</p>	
<p>RESIDENCE Baltimore, Md.</p>		<p>PLACE OF DEATH Baltimore, Md.</p>	
<p>DATE OF BIRTH June 2, 1958</p>		<p>AGE 35</p>	
<p>SEX Male</p>		<p>RACE White</p>	
<p>EDUCATION High School</p>		<p>OCCUPATION None</p>	
<p>RELIGION None</p>		<p>CAUSE OF DEATH None</p>	
<p>DATE OF DEATH June 2, 1958</p>		<p>PLACE OF DEATH Baltimore, Md.</p>	
<p>DATE OF BIRTH June 2, 1958</p>		<p>AGE 35</p>	
<p>SEX Male</p>		<p>RACE White</p>	
<p>EDUCATION High School</p>		<p>OCCUPATION None</p>	
<p>RELIGION None</p>		<p>CAUSE OF DEATH None</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6915

## CERTIFICATE OF DEATH

Reg. Dist. No.

06909

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fulton</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills</u> <u>16 x - 2</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Simon Rest Home</u>				d. STREET ADDRESS <u>RTZ 5150 St Barnabas Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Morris</u> Last				4. DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 24th 1875</u> <u>82</u> yrs.	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>58</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>New York City N.Y.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Walsh</u>				14. MOTHER'S MAIDEN NAME <u>Alice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Alice C. Hope</u>		Address <u>Same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC FAILURE</u> <u>1420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERY OCCLUSION</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>INST.</u> <u>INST.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 16, 1957</u> , to <u>JUNE 1, 1958</u> , that I last saw the deceased alive on <u>MAY 31, 1958</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.				ADDRESS (Street, city or town, state) <u>CLARKSVILLE MD</u>		DATE SIGNED <u>6/1/58</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER M.D.</u>				<u>Clarksville, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-4-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Mattingly</u>				ADDRESS <u>131-11th St</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 4 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	



6916

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> <b>19X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Taylor Manor Hospital</b>				d. STREET ADDRESS <b>R.F.D. #1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>William Oran</b> Middle <b>Murray</b> Last <b>Murray</b>				4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/7/87</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>		11. BIRTHPLACE (State or foreign country) <b>Mt Vernon, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Eben Murray</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Austin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>John Murray</b> Address <b>R.F.D. Princess Anne, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arterio sclerosis, generalized, severe</b> (c) <b>Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Decubitus ulcers, back</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 26, 1958</b> , to <b>June 9, 1958</b> , that I last saw the deceased alive on <b>June 9, 1958</b> , and that death occurred at <b>2:35 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stephen Lee Magness</b> M.D.				ADDRESS (Street, city or town, state) <b>Taylor Manor Hospital</b>		DATE SIGNED <b>6/9/58</b>	
PHYSICIAN'S NAME (Type) <b>Stephen Lee Magness, M.D.</b>				<b>Ellicott City, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6/11/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Vernon, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Hunnan</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 13 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6917

## CERTIFICATE OF DEATH

Reg. Dist. No.

06911

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u>	c. LENGTH OF STAY IN IB <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carey Lane</u>		d. STREET ADDRESS <u>Carey Lane</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>M</u> Last <u>POWELL</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Docomoka City</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>William Tilghman</u>	
14. MOTHER'S MAIDEN NAME <u>Mary M. Powell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Robert R. Powell Carey Lane</u> Address <u>Woodstock Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC failure, bronchial pneumonia,</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis, Arteriosclerotic</u> DUE TO (c) <u>heart dis. Arteriosclerosis generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1957</u> <u>to</u> <u>17 June 58</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>58</u> , to <u>17 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>17 June</u> , 19 <u>58</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Severn, Md</u> DATE SIGNED <u>17 June 58</u>	
PHYSICIAN'S NAME (Type) <u>Spring Byers</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Capital</u>	22b. DATE THEREOF <u>6/21, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivé</u>	22d. LOCATION (City, town, or county) (State) <u>Randallstown, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Spring Byers 8728 Liberty Road</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 23 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DAY IS

PLACE OF DEATH		DATE OF DEATH	
PLACE OF BIRTH		DATE OF BIRTH	
MARRIAGE		DATE OF MARRIAGE	
EDUCATION		DATE OF EDUCATION	
OCCUPATION		DATE OF OCCUPATION	
RELIGION		DATE OF RELIGION	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH	
MANNER OF DEATH		DATE OF MANNER OF DEATH	
SIGNATURE OF DECEASED		DATE OF SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS		DATE OF SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE OF PHYSICIAN	
SIGNATURE OF CLERGYMAN		DATE OF SIGNATURE OF CLERGYMAN	
SIGNATURE OF JUDGE		DATE OF SIGNATURE OF JUDGE	
SIGNATURE OF SHERIFF		DATE OF SIGNATURE OF SHERIFF	
SIGNATURE OF CORONER		DATE OF SIGNATURE OF CORONER	
SIGNATURE OF JURY		DATE OF SIGNATURE OF JURY	
SIGNATURE OF COURT		DATE OF SIGNATURE OF COURT	
SIGNATURE OF STATE		DATE OF SIGNATURE OF STATE	
SIGNATURE OF NATION		DATE OF SIGNATURE OF NATION	
SIGNATURE OF WORLD		DATE OF SIGNATURE OF WORLD	
SIGNATURE OF UNIVERSE		DATE OF SIGNATURE OF UNIVERSE	
SIGNATURE OF GOD		DATE OF SIGNATURE OF GOD	
SIGNATURE OF HEAVEN		DATE OF SIGNATURE OF HEAVEN	
SIGNATURE OF EARTH		DATE OF SIGNATURE OF EARTH	
SIGNATURE OF WATER		DATE OF SIGNATURE OF WATER	
SIGNATURE OF FIRE		DATE OF SIGNATURE OF FIRE	
SIGNATURE OF AIR		DATE OF SIGNATURE OF AIR	
SIGNATURE OF LIGHT		DATE OF SIGNATURE OF LIGHT	
SIGNATURE OF DARKNESS		DATE OF SIGNATURE OF DARKNESS	
SIGNATURE OF LIFE		DATE OF SIGNATURE OF LIFE	
SIGNATURE OF DEATH		DATE OF SIGNATURE OF DEATH	

## CERTIFICATE OF DEATH

Reg. Dist. No.

06912

6918

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto. Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Woodley &amp; Whitehall Rds.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Evelyn Haines Smith</u>				4. DATE OF DEATH Month Day Year <u>June 30, 1958</u> 19			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 18, 1907</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Milton Haines</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Carlton E. Smith, Ellicott City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertensive C.V. D</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1955</u> , to <u>June 30, 1958</u> , that I last saw the deceased alive on <u>June 30, 1958</u> , and that death occurred at <u>10:20 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Catonsville</u> <u>7-1</u>							
ACTUAL SIGNATURE <u>James S. Howarf</u> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-3-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Maedowridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Elkridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Farley Funeral Home Catonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6919

## CERTIFICATE OF DEATH

Reg. Dist. No.

06913

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>		c. LENGTH OF STAY IN 1b <b>40 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2103 Furnace Ave.</b>		d. STREET ADDRESS <b>2103 Furnace Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John A.</b> Middle <b>Smith</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 17, 1892</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. RR.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW1</b>	
17. INFORMANT <b>Madeline M. Smith</b>		Address <b>2103 Furnace Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> DUE TO <b>chr myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO <b>hypertension</b> (c) <b>general arterio-sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 mo</b> <b>3 yrs</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>57</b> , to <b>June 27</b> 19 <b>58</b> , that I last saw the deceased alive on <b>June 21</b> , 19 <b>58</b> , and that death occurred at <b>4 a.m.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B B Brumbaugh</b> M.D.		ADDRESS (Street, city or town, state) <b>7109 Nant St</b> DATE SIGNED <b>6/23/58</b>	
PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>		<b>Elkridge Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/25/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ambrase Inc. 1328 Sulphur Spring Rd.</b>		ADDRESS <b>Baltimore Md</b>	
24a. REC'D BY REGISTRAR <b>JUN 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

CERTIFICATE OF DEATH

Name of Deceased <b>Howard</b>		Age <b>10 yrs.</b>		Sex <b>Male</b>		Race <b>White</b>		Date of Death <b>May 17, 1962</b>		Place of Death <b>Home</b>	
Address <b>515 Linn Ave.</b>		City <b>Baltimore</b>		County <b>Harford</b>		State <b>Md.</b>		Country <b>U.S.A.</b>		Hospital or Physician <b>None</b>	
Cause of Death <b>Unknown</b>		Manner of Death <b>Unknown</b>		Occupation <b>None</b>		Education <b>None</b>		Religion <b>None</b>		Marital Status <b>None</b>	
Signature of Physician <b>None</b>		Signature of Coroner <b>None</b>		Signature of Registrar <b>None</b>		Signature of Informant <b>None</b>		Signature of Witness <b>None</b>		Signature of Deceased <b>None</b>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6920

## CERTIFICATE OF DEATH

06914

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN 1b <u>5 mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaffer's Convalescent Retreat</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>L</u> Last <u>Swann</u>		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1927</u>
9. AGE (In years last birthday) <u>31</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chas Henrickle</u>		14. MOTHER'S MAIDEN NAME <u>Emma Coleman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Mildred Haney</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 da.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>June 9, 1958</u> to <u>June 9, 1958</u> , that I last saw the deceased alive on <u>June 9, 1958</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas Z. Herbert</u> M.D.		ADDRESS (Street, city or town, state) <u>Ellicott City, Md.</u>	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED <u>6/10/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 13, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Olivet</u>	22d. LOCATION (City, town, or county) <u>Balto., Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Synter</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 16 '58</u>	24b. REGISTRAR'S SIGNATURE <u>John Smith</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

**DECEASED**  
Name: John Doe  
Date: 10-15-1965  
Age: 45  
Sex: M  
Race: W  
Marital Status: M  
Occupation: Teacher  
Cause of Death: Heart Disease  
Place of Death: Home  
Signature: [Signature]  
Date: 10-15-1965

MAIN BOARD

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6921

## CERTIFICATE OF DEATH

Reg. Dist. No. 06915

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 6, Md.</b> <b>3 Vol. 4</b>			
c. LENGTH OF STAY IN 1b <b>3 mos.</b>				d. STREET ADDRESS <b>4117 Marx Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Taylor Manor Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>W</b> Last <b>Walston</b>				4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/29/72</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Somerset Co</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Charles Walston</b>				14. MOTHER'S MAIDEN NAME <b>? Pruett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Leota McNamara 4117 Marx Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Myocardial failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Arteriosclerosis generalized</b> (c) <b>Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis; decubitus ulcers</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/28</b> , 19 <b>58</b> to <b>June 10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 10</b> , 19 <b>58</b> , and that death occurred at <b>6:04 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Taylor Manor Hospital</b> DATE SIGNED <b>6/10/58</b> ACTUAL SIGNATURE <b>Irving J. Taylor</b> M.D. <b>Ellicott City, Md.</b> PHYSICIAN'S NAME (Type) <b>Irving J. Taylor, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June. 13, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Parkville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 4210 Belair Road.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. A. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6922

CERTIFICATE OF DEATH

06916

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Box 332 H.R. Montgomery</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge 27 Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		1d. STREET ADDRESS <u>Box 332 H.R. Montgomery</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Joseph</u> Last <u>Woodcock</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1978</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 13-1901</u>
9. AGE (In years—last birthday) <u>76 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-03-1237</u>	
17. INFORMANT <u>Mrs Helen Bata Woodcock</u>		Address <u>Box 332 H.R. Montgomery 27 Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arterio-sclerosis</u> 4 yrs (c) <u>Arterial Hypertension</u> 4 yrs		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1958</u> , to <u>June 8, 1978</u> , that I last saw the deceased alive on <u>June 7, 1978</u> , and that death occurred at <u>10:40</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B B Brumbaugh</u> M.D.		DATE SIGNED <u>6/8/78</u>	
PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>		<u>Elkridge 27 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-11-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Wash Blvd Howard CO Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Toulson</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 10 '78</u>	
ADDRESS <u>2359 Wash Blvd Balto 30 Md</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

